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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00102110. This visit resulted in a partially extended survey-immediate jeopardy-past noncompliance. Complaint IN00102110 - Substantiated. Federal/state deficiencies related to the allegation are cited at F323. Survey dates: January 17, 18, 2012 Extended survey date: January 19, 2012 Facility number: 000058 Provider number: 155133 AIM number: 100283340 Survey team: Diana Sidell RN, TC Jill Ross RN Census bed type: SNF/NF: 162 Total: 162 Census payor type: Medicare: 26 Medicaid: 115 Other: 21 Total: 162 Sample: 3 Supplemental sample: 1 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 1/23/12	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Cathy Emswiller RN	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and observation, the facility failed to ensure residents assessed as dependent smokers received adequate supervision during smoking to prevent accidents in that 1 resident's clothing caught on fire and he received 1st, 2nd, and 3rd degree burns (Resident B) and 1 resident who tried to extinguish the flames received 1st and 2nd degree burns. (Resident A) This deficient practice affected 2 of 3 residents reviewed for supervision during smoking in a sample of 3 and had the potential to affect 7 other residents who smoked in the facility. This deficient practice resulted in immediate jeopardy. The immediate jeopardy was identified on 1/17/12 and began on 1/5/12. The facility Executive Director and Director of Health Services was notified of the immediate jeopardy regarding inadequate supervision of residents during smoking on 1/17/12 at 4:50 p.m. The immediate jeopardy was removed, and the	F 323	Past noncompliance: no plan of correction required.	

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deficient practice corrected, on 1/6/12 prior to the start of the survey and was therefore Past Noncompliance.

Findings include:

1. Resident progress notes dated 1/5/12 at 2:00 p.m. indicated: "@ approx. 1:15 p.m. this nurse on hall passing trays responded to CNA calling for assistance on the smoking patio. This nurse responded immediately to find res (resident) [with] shirt off, clothing on the ground, shinged (sic) areas to chest, arm (L) and (L) neck noted. This nurse immediately checked for any hot areas that may still be burning, all "hot areas" removed, res brought inside, taken to room wash cloths and towels soaked in cold water and applied to areas of concern. [No] S&S (signs and symptoms) of resp[iratory] distress v/s (vital signs) 130/66, 88, 16, 98. Administrator, MD, and sons [names of sons] notified. N.O. may send to ER for eval et tx. Hospice also aware [local ambulance service] to transport. While awaiting transport res given prn (as needed) dose of Roxanol (narcotic pain reliever) as well as ice packs applied to areas of concern. Report called to [local hospital] ER. Transported @ approx 1:30 p.m."

The clinical record of Resident B was reviewed on 1/17/12 at 12:48 p.m. The record indicated Resident B was re-admitted on 10/1/11 with diagnoses that included, but were not limited to, bipolar, depression, anxiety, Parkinson's disease, tremor, chronic obstructive pulmonary disorder, anemia, high blood pressure, end stage stroke, right posterior brain bleed, and tobacco use disorder (excessive smoking), and was placed on

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F 323	Continued From page 3 hospice on 12/23/11. A smoking evaluation dated 12/5/11 indicated Resident B was unable to physically hold the smoking device while smoking and could not demonstrate "understanding that smoking materials are for use only in designated smoking areas." The results indicated he was a dependent smoker: "...The resident needs assistance and/or supervision while smoking as determined by the Interdisciplinary Team. Smokes only at designated times and places with supervision and/or assistance. May need and/or wear protective smoking vest/apron ...." The Care Plan on the bottom half of the smoking evaluation indicated: "Smoking designation (Dependent)...Identifies protective gear (smoking apron). Other specific concerns/plans: Non-compliant [with] facility smoking policy...." A care plan with an onset date on 6/16/10 indicated a problem of "Potential for injury (burn) R/T (related to) RD (resident) is a smoker. Goal: No injuries to self or others secondary to RD's smoking. Approach: All staff to report any changes in RD's cognition or sensory status to interdis[iplinary] team. IDT to assess RD upon admission and annually & prn with safe smoking assessment form. All smoking material to be kept at nurses station per policy. Res non compliant with smoking policy. Resident to wear smoking apron while smoking, however resident non compliant with wearing smoking apron." A new approach dated 1/3/12 indicated "non-compliance [with] smoking policy." Approaches added 1/5/12 indicated: "Non compliance [with] wearing apron. Resident will be reminded of smoking times & policy & designated	F 323		

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smoke area. Offer nicotine patch in place of smoking."

The following statement indicated that CNA #1 had been inside the facility observing from a window and did not adequately monitor the residents who were smoking. The window was approximately 10 feet from the door and required staff to enter a code into a key pad beside the door to exit the lounge to go onto the smoking patio:

A written statement from C.N.A. #2, dated 1/7/12, indicated: "On Thursday January 5th, 2012 I was working on the 300 hall with [LPN #3] as the nurse and [C.N.A. #1] as the other CNA. At 1:00 p.m. [CNA #1] was asked to take the smokers out to smoke. While walking down the hall I saw [CNA #1] sitting in the 300 hall lounge watching the smokers. I then took a lunch tray to room 317 while in there I heard [CNA #1] yell "we need help out here!" I then took off down the hall. When I turned the corner into 300 hall lobby/lounge I saw [Resident B] up in flames. As I was running towards the door outside [CNA #1] ran into the building towards the nurses station. As I was trying to get out of the door [Resident A] jumped up & started taking [Resident B's] shirts off. As soon as I got out there I told [Resident A] and all other residents to stay back & finished pulling off [Resident B's] shirt. I then proceeded to step the fire on [Resident B's] pants and brief out...."

A written statement from Resident D dated 1/5/12 indicated: "[Resident B] lit his cigarette. None of us were given a smoking apron. Staff was in lounge watching from the window. [Resident A] got up ran to him & started pulling [Resident B's]

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clothes off & [Resident C] helped...the CNA stood there watching for a minute before doing anything. She came outside & tried to help...."

Resident progress notes dated 1/5/12 at 11:00 p.m. indicated: "Res returned to facility from [local hospital] at 6:30 p.m. Dsg (dressing) to chest D/I (dry & intact)...."

Care plans updated dated 1/5/12 indicated: "Problem: Blisters on eye lids and lips d/t burns. Goal: No S/SX infection. Approach: Observe for S/Sx of infection redness, drainage, swelling, tx as ordered, pain medication as ordered, encourage fluids. Problem: Burns Goal: resolve. Approach: Silvadene cream BID (twice a day) Vicodin 1 po (by mouth) [every four hours] prn, Vicodin 2 po [every fours hours] prn, Wound care eval, Monitor for S/SX of infection redness, drainage, elevated temp. swelling."

Resident progress notes dated 1/6/12 at 2:00 a.m. indicated: "...Son request to wash hands of res as he kept touching drsgs and pulled them off again. Drsgs reapplied [with] lg (large) aquaphor drsgs. Silvadine applied again. Bacitracin to eye lids & lip areas. Res states pain is "not too bad."...."

Resident progress notes dated 1/6/12 at 10:10 a.m. indicated: "Res. abed supine position [with] chest area exposed: Noted [with] 5-6 O/A Partial thickness [no] odor [no] drainage: multi-fld (fluid) filled blisters noted to [upper] chest and throat area, R) bicep area [with] multi fld filled Blisters: Area noted to chin open partial thickness 100% [no] S/S infection R) [lower] side lip noted [with] med. size clear fld filled Blisters [no] drainage

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noted. L) hand 2nd digit [with] fld filled Blister X 1: [no] S/S infection [no] odor...RLE [with] sm. clear fld filled blister noted to medial [upper] thigh area: [no] drainage: Res. awake during visual assessment talking [with] this writer: Pleasant: cont. to deny any discomfort at this time: Raises self [up] in bed, [without] difficulty, to obtain drink of beverage from cup on overbed table...Upon further assessment of skin, per visual, [no] addition areas noted R/T event. Res. cont to deny pain or discomfort. MUE (moves upper extremities) [without] difficulty...."

A NP (nurse practitioner) note dated 1/6/12 indicated: "...Pt (patient) burned self when outside smoking in designated area. Pt sent to ER per T.O. (telephone order), treated, returned. Pt [with] 2nd & 3rd degree burns to face, neck, arm, chest."

A Physician's order dated 1/6/12 indicated an order to "Send to [another facility] eval & tx as needed."

Resident progress notes dated 1/6/12 at 7:40 p.m. indicated: "Resident picked up and transferred to [other facility] via [ambulance service] paperwork given to ambulance personal."

A hospice note from a local facility, dated 1/9/12 at 1:30 p.m., indicated: "Received call from [nurse at another hospital] who reports burn team MD does not feel pt meets IP (in patient) criteria to be admitted @ [hospital] & that Son, [name of son] et Kindred of Columbus

A "facility investigation of burns caused by

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cigarette" was provided by the Executive Director on 1/17/12 at 12:13 p.m. and included, but was not limited to, "Around 1:15 p.m. on 1/5/12 the Director of Nursing was called to the 300 hall lounge. [Resident B] had been outside in the smoking area smoking and his clothing had caught fire. ED and DNS went to the smoking area and the nurse [name] took [Resident B] to his room for examination. Residents were outside smoking and per resident statements all of a sudden [Resident B] was on fire, another resident [A] ran up to [Resident B] and started pulling [Resident B's] coat and shirt off. [Resident A] was able to remove the coat and get the shirt half way off when Nursing assistant [#1] arrived and removed the shirt. And [C.N.A. #1] tossed shirt to the ground. [Resident A] received burns to his right [was actually the left] hand. At that time the nursing staff was running out. Another resident [C] began stomping the clothing to put out the fire. Residents stated it happened really quickly and just burst into flames...Investigation was immediately initiated by the DON and ED, with management involved to assist with resident and staff interviews. The Generations unit manager [name] and Social Service Director [name] were also suspended pending investigation due to responsibility of ensuring the staff follow the "Smoking Policy" and maintain resident safety on their assigned unit. Upon investigation found the residents had not been wearing smoking aprons and had smoking material (cigarettes and lighters) upon their person. The Nursing assistant [CNA #1] and [LPN #3] that were assigned to supervise the smokers were both immediately suspended pending investigation."

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A written statement from CNA #1 indicated: 1/5/12: "At around 1:00 p.m., I came back from the dining room & went to 300 Hall where I was assigned today. [LPN #3] told me to "stand in the 300 hall lounge & to just watch the smokers." I was standing there looking out the window. A resident who was out there smoking all of a sudden started limping over to [Resident B's] chair & I ran outside & started yelling to whoever I saw that we needed help out on patio. Staff came out & assisted the residents into the building. I was directed to DON's office to write this statement. I was not told about the aprons or who needed one. I did what the nurse told me."

A "Facility Incident Reporting Form" indicated the incident occurred on 1/5/12 at 1:15 p.m. Residents involved were Resident A, B, and C. A brief description of the incident included: "[Resident C] was out smoking a cigarette at smoke time; [Resident A], another resident noticed fire on [Resident B]. [Resident A] another smoker went to [Resident B], [Resident A] was pulling his shirt off. C.N.A. responsible for smoking supervision yelled for help, nursing staff responded to assist. When the shirt was off on the ground [Resident C] went over and was stomping on the shirt, he received no injuries. The residents were escorted by nursing back into the facility. Type of injury/injuries: [Resident B] received 1st, 2nd, and 3rd degree burns to torso, neck, and face. [Resident A] received 1st, 2nd, 3rd degree burns to his left hand. Immediate Action Taken: [Resident B] was cleansed and first aid was administered.; sent to ER for evaluation; [Resident B] returned to the facility from ER after treatment. [Resident A's] hand was cleansed, silvadene applied and dressed.

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Physicians and families were notified. [Resident B] came back to facility, with treatments and pain medication orders. On 1-6-12 facility discussed with [Resident B's] family and decision was made to send to the [other facility] for more indepth treatment. At the [other facility] [Resident B] was seen by the physician and wound team. [Resident B] was to be seen at the [hospital] for evaluation and further treatment. After arriving at the burn center the physician spoke with family and due to not treating pre-existing diagnoses of a terminal brain bleed and failure to thrive, which is being followed by hospice and being a DNR, the family opted to not treat the burns. [Hospice] was consulted and agreed to accept [Resident B] in house."

"[Resident A] was seen by [wound center], the Physician debrided and cleansed the wounds on his hand, administered and ordered a treatment and antibiotic. Pain medicated was obtained for this resident. [Resident A] is to be seen by [burn center] on 1-11-2012."

"Preventive measures taken: The staff was inserviced on the smoking policy and the smoking blanket. The residents received education reference the smoking policy. Each smoker was instructed that they were required to wear a smoking apron during smoking times. It was explained to the smokers that if they did not comply with the smoking policy they would be given a 30 day notice of discharge. Each smoker had a new smoking evaluation completed. Each smoker's care plan and C.N.A. assignment sheet were updated. The smoking policy was reviewed with the family or point of contact and they were instructed that all smoking materials need to be

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turned in at the nurse's station and then the staff will distribute at the appropriate times. The family member was made aware that if the resident is not compliant with the smoking policy they will be issued a 30-day notice. The smokers will be monitored by two people during smoking times. The smokers rooms were checked for any smoking materials. Facility residents' skin was checked..."

On 1/17/12 at 12:58 p.m., residents who smoked were observed on the patio off the 300 hall. Three residents were seated in wheelchairs and five were seated in patio chairs. Five staff observed the residents and lit their cigarettes. Residents all wore smoking aprons. The observation also indicated the area where CNA #1 had stood on 1/5/12 was approximately 10 feet from the door and required staff to enter a code into a key pad on the door to exit the lounge.

On 1/17/11 at 4:45 p.m., the Executive Director indicated CNA #1 didn't want to go outside with the residents, the nurse said she could watch from the window, and that the CNA wasn't usually on that hall. She indicated the nurse, the CNA, the unit manager, and Social Service director were all suspended and then terminated. When queried why the smoking apron was not on the resident, the Executive Director indicated it was an "error by the CNA" and that the residents sometimes say they don't want to wear them and the CNA didn't put them on. She further indicated all staff are responsible for the policy and procedure for smoking to be followed and they have been trained to do that.

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2. Resident A's record was reviewed on 1-17-12 at 12:00 p.m.. The record indicated that Resident A was admitted with diagnoses that included but were not limited to, chronic kidney disease, diabetes, congestive heart failure, and hypertension (high blood pressure).

An annual MDS indicated Resident A was independent for cognitive skills for daily decision making, had no mood or behavior problems, used a wheel chair for mobility out in halls due to bledsoe boot [foot brace] on right foot, and had no limitation in range of motion.

Smoking assessments dated 4/19/11, 10/5/11 and 1/5/12 indicated Resident A was evaluated to be a dependent smoker and was "non-compliant with facility smoking policy". The assessment dated 1/5/12 indicated resident was to wear a smoking apron as protective gear.

Resident progress notes dated 1/5/12 at 2:00 p.m. indicated: "@ (at) approx (approximately) 115pm (1:15 p.m.) res (resident) sustained an injury to his (L) (left) hand while helping another res remove clothing during an emergency. (L) forefinger presents [with] blister as well as small area on (L) palm. Cold towel applied to area immediately, then ice pack applied. DON (director of nursing), Administrator, unit manager, MD (doctor) notified. Sister [name] also notified."

A resident progress note dated 1/5/12 9:00 p.m. indicated: " Reassessed areas to res (L) hand. [No] [change] noted except to middle finger. Blisters intact to finger but finger is edematous and tight. Fingers warm, color normal for skin tone and free of drainage. Res states pain

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present to all sites [without] [increase] in pain from earlier assessment. Will cont (continue) to monitor. Cont. [with] Silvadene, adaptic and gauze dressing. Will notify MD of any further [changes]."

A Condition Change Form dated 1/5/12 indicated: "c/o (complain of) pain d/t (due to) burns to (L) hand - NO (new orders) rc'd (received) for morphine sulfate 10 mg/ml (milligrams per milliliters) give 0.2 ml IM (intramuscularly) q4 (every 4 hours) x (times) 48 [hours]."

A resident progress note dated 1/5/12 at 10:00 p.m. indicated: "... Res c/o pain to all sites..." One dated 1/6/12 at 0630 (6:30 a.m.) indicated: "Resident requested Morphine IM x2 this shift...Bandage remains to hand...."

A resident progress note dated 1/6/12 at 1:10 p.m. indicated: "Bandage [changed] to (L) hand this shift. Blisters remain as previously noted. Middle finger remains edematous [with] limited mobility of finger. There are [no] drainage or other s/sx (signs or symptoms) of infection to any sites. Requested res to be evaluated [at] wound center for f/u (follow-up) of injury. Res will be seen by [physician's name] (at) wound center today...."

A Condition Change Form dated 1/6/12 indicated: "N.O. (new order) Keflex 500 mg [two] po (by mouth) BID (two times per day) #40 (number of pills) cont for 20 days."

A Condition Change Form dated 1/6/12 indicated: "N.O. drsg (dressing) to (L) hand and fingers d/t burn. Apply Silvadene cream, cuticerin, wrap

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING _____ B. WING _____	C 01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	2100 MIDWAY ST COLUMBUS, IN 47201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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[with] gauze, and secure [with] tape. [change] drsg daily."

A resident progress note dated 1/8/12 at 1:30 p.m. indicated: "...Fluid filled blisters to all fingers and base of thumb. c/o extreme pain. Medicated prior to drsg [change]."

A nurse assessment note from the wound center dated 1/17/12 indicated: "...male who sustained...thermal burns to left hand in scattered areas on 1/5/12... Patient reports attempting to extinguish the flames when his friend's clothing caught fire. Patient was treated at an outside wound center on 1/6/12 and returned to the nursing facility where he resides.... First webs (space between thumb and first finger) has slight maceration (broken, peeling skin) noted on edge of wound, pseudoeschar (black charred skin) noted on wound bed. Open areas noted to palmar (palm) surface and dorsal (back) surface of 4th digit."

A smoking policy and procedure with an effective date of 10/31/10 was provided by the DON on 1/17/12 at 11:50 a.m. The policy included but was not limited to "Rationale: Patients who desire to smoke are assessed to reduce risks to the patient to determine level of supervision needed including the risk of fire and/or injury. Procedure: 1. Identify patients who desire to smoke. 2. Determine the patient's independence and/or dependence with smoking ability and the need for protective gear upon admission, then quarterly, annually, with a significant change or as needed as determined by the interdisciplinary team... 3. Educate patients and/or legal representative on smoking policy, smoking

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	155133	A. BUILDING _____ B. WING _____	C 01/19/2012

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locations and smoking times. 4. Educate staff on smoking policy, smoking locations and smoking times. 5. Plan, schedule and post smoking times and monitor smoking patients. 6. Assign staff to supervise patients smoking in designated smoking areas at the appropriate time frames...8. Provide protective wear, as necessary (i.e., Smoking aprons, etc.) 10. Provide assistance and/or supervision as necessary."

The past noncompliance immediate jeopardy began on 1/5/12. The immediate jeopardy was removed and the deficient practice corrected by 1/6/12 after the facility implemented a systemic plan that included the following actions: Facility residents' skin was checked, smoker's rooms were checked for smoking materials, and smokers received education on the smoking policy and times. Smokers were instructed they were to wear a smoking apron during smoking times and a new smoking evaluation was completed on each smoker. Each smoker's care plan and C.N.A. assignment was updated. Each smoker's family or point of contact were instructed that all smoking materials need to be turned in a the nurse's station and staff will distribute at the appropriate times. Stall were inserviced on the smoking policy, how to supervise smokers, and how to administer first aid to burns. The Director of Nursing Services or Designee will monitor that smoking materials will be locked in a cabinet, signs that say "no smoking" outside of facility, smoking aprons, fire blanket and fire extinguisher centrally located on the patio. Fire safety approved ashtrays will be on the patio. Staff will pass out cigarettes and light cigarettes. The smoking policy and how to supervise smokers will be reviewed with staff

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	155133	A. BUILDING _____ B. WING _____	C 01/19/2012

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F 323	Continued From page 15 during orientation and monthly times three months, or until compliance is met, then yearly and as needed. Maintenance/Designee will check the patio two times a day for fire safety approved ashtrays, condition of the smoke aprons, fire blanket and fire extinguisher and any inappropriate items. The Executive Director will review the audit results for three months or until compliance is achieved. This Federal tag relates to complaint IN00102110. 3.1-45(a)(1) 3.1-45(a)(2)	F 323		